Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WOLMED

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-11-2959-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The total for the DME is not over $500.00. The preauthorization denial is invalid. ODG recommends home exercise equipment for lumbar injuries."

Amount in Dispute: $359.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor apparently provided home exercise equipment to the claimant on 5/10/10. The compensable injury is to the lumbar spine. Notwithstanding the requestor's assertion that ODG recommends home exercise equipment, neither the requestor nor Texas Mutual can supply the ODG site recommending home exercise equipment from the low back or any other ODG treatment guideline. Because there is no statement from ODG expressly recommending home exercise equipment for lumbar injuries, preauthorization was required. Texas Mutual reviewed its claim file and found no preauthorization request for such equipment from the requestor."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2010	A9999 x 2 and A9300 x 2	$359.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §137.100 sets out the Treatment guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 930 – Denied in accordance with 134.600(p)(12) as the treatment/service is in excess of the division's treatment guidelines s outline in the disability management rules effect 5/1/07. Please refer to the disability management rules, chapter 137 on the division's website.
   - CAC-B18 – This procedure code and modifier were invalid on the date of service.
   - CAC-197 – Precertification/authorization/notification absent.
   - 893 – This code is invalid or not covered or has been deleted.
   - 903 – Pre-authorization required, reimbursement denied.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 762 – Denied in accordance with 134.600 (p) (12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.
   - 891 – No additional payment after reconsideration.

Issues

1. Is preauthorization required for the disputed charges?
2. Did the requestor obtain preauthorization for the disputed charges?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)."

   The disputed billed charges are under the $500.00 threshold and are therefore subject to the requirements of 28 Texas Administrative Code §134.600 (p) (12).

   Per 28 Texas Administrative Code §134.600 "(p) (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."
2. Per 28 Texas Administrative Code §137.100 "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)."

   Per 28 Texas Administrative Code §137.100 "(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

   The requestor seeks reimbursement for HCPC Level II code A9999 defined by the AMA CPT Code Book as follows "Miscellaneous DME supply or accessory, not otherwise specified."

   The requestor seeks reimbursement for HCPC Level II code A9300 defined by the AMA CPT Code Book as follows "Exercise equipment."

   The requestor submitted documentation to support that physical therapy is a recommended treatment for Low Back – Lumbar & Thoracic (Acute & Chronic), however, the documentation does not include a reference to the miscellaneous DME supply and the exercise equipment, which is in dispute. As a result, the disputed charges are subject to preauthorization.
3. Review of the submitted documentation finds that the disputed charges were not preauthorized as required per 28 Texas Administrative Code §137.100, as a result $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June 23, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.